

## **Application**

# **Credentialing Review for Expanding Scope of Practice for Dental Hygiene & Establishing a Scope of Practice in Statute for Dental Assisting**

## **Breaking Down Barriers: Oral Health Care Stakeholders Working to Expand Access to Dental Care for Underserved Populations**

**Submitted by:**



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## Overview of Proposal

In Nebraska, dental care is primarily delivered in private practice settings that are led by a dentist and typically include a team of business staff, dental hygienists, and dental assistants. Dental hygienists and dental assistants usually work in the private sector where the majority of Nebraskans receive dental care. A minority of Nebraskans seek care through community health centers; public health clinics offered by the dental schools; and through charitable projects. Preventive services are available on a limited basis through programs like the school-based sealant programs, Head Start and/or WIC Clinics, and long-term care settings. Unfortunately, dental services for the minority of Nebraskans who must seek such services through public and charitable entities are sporadic and highly dependent on the willingness and availability of dentists and the availability of funds through grants and public and private funding sources.

Within a dental team, the dentist is the primary dental service provider who is supported by dental hygienists and dental assistants. Dental hygienists primarily care for patients' overall dental disease prevention needs that includes: taking medical histories, performing blood pressure screenings; taking radiographs; cleaning teeth; placing dental sealants; providing local anesthesia to patients in a dental practice only; and educating the patient on home care to prevent dental disease. Dental hygienists also do procedures such as scaling, root planning and palliative treatment. Dental assistants primarily assist the dentist with restorative and surgical procedures, sterilize instruments and may also perform the following additional duties with an approved course: coronal polishing (polishing teeth above the gum line and only with a polishing cup); and taking radiographs.

Dental hygienists have either an associate degree or a bachelor degree, and all have a license to practice dental hygiene in Nebraska. Dental assistants are not licensed, and are either trained in accredited dental assisting programs or are provided on-the-job training. Therefore, there is not a registry for dental assistants. Dental assistants are prohibited from taking radiographs and performing coronal polishing, unless they first participate in a 2-day training on such procedures.

In addition to working in a private practice settings, some dental hygienists also work in public health settings such as schools, prisons, community health centers, Women, Infant, and Children (WIC) Clinics, and nursing homes. In 2007, Nebraska passed a law that authorized dental hygienists to apply for a public health permit that gives dental hygienists greater autonomy and flexibility to reach these high risk populations without having a dentist on site. In public health settings, dental hygienists provide their services to high risk populations that may or may not be able to routinely seek the care of a dentist nor have a dental home. One example of this would be placing sealants in a school-based dental sealant program.

According to the Institute of Medicine, 1 out of every 16 children in the United States did not receive needed dental care in 2008, because their families could not afford it (*Institute of Medicine Report Brief*, July 2011). Specifically, the Institute of Medicine Committee on Oral Health recommended that state legislatures amend existing state laws to maximize access to oral health care. Such changes would allow professionals to practice to the full extent of their education and training in a variety of settings and facilitate technology-based collaboration and supervision.

In 2009, 830,000 visits to emergency rooms around the country could have been prevented if the patients had seen a dentist earlier. In 2011, more than half of children on Medicaid went without dental care. For example, in 2007, Deamonte Driver, a 7<sup>th</sup> grade Maryland boy, died of a preventable infection that spread from his mouth to his brain. As a result of Deamonte's death, Maryland pushed

through reforms that expanded the availability for dental care for individuals like Deamonte. Unfortunately the situation across the country has not dramatically improved for the underserved and unserved populations in the area of dental care. For these populations, the point of access must be expanded, including in Nebraska.

In Nebraska, approximately only one-third of Nebraska dentists see Medicaid eligible patients. While numerous efforts have been attempted to encourage more dentists to treat this specific population, the low reimbursement rates, along with other administrative barriers and challenges inherent in this patient population have proved to be more difficult to overcome.

There is a dental care crisis in the United States, particularly among people in poor or rural areas. People who have dental insurance or the means to pay out of pocket can get a high level of care. Those without struggle. Medicaid covers dental services, but underserved and unserved populations have difficulty finding a dentist who participates in the program, because the reimbursements do not cover the dental services provided. In less-populated areas, sometimes regardless of their ability to pay, patients may have to travel hours to receive dental care.

A large body of research supports the impact of oral health on total health. Health professions, the public, and the states recognize the need to have access to preventive, cost-effective oral care services for all populations. Unfortunately, the number of dentists is decreasing. Fortunately, the number of dental hygienists is increasing with a 38% projected growth from 2010 to 2022. The aging population is keeping more teeth longer, and with longer life expectancy will increase demand for oral care services.

Though opinions about how to expand access to care may differ among dental professionals, one solution is in expanding the *scope of practice* for dental hygienists. Dental hygiene's current workforce is ready and willing to help provide a solution to the current access problems. With the Affordable Care Act (ACA) in place and the demands on states to provide accessible, safe and high-quality oral health care, expanding the scope of practice and supervision for dental hygienists should be a priority for Nebraska. Currently, dental hygienists in 36 states can legally provide direct access care. Dental hygienists are providing preventive services in a variety of settings to previously un-served and under-served Americans, with referral to dentists for specific dental needs. If dental hygienists are free to practice to the full extent of their licenses, then more underserved and unserved patients will be able to access oral health care in both urban and rural settings.

Another potential solution is to expand the *scope of services* a dental hygienist is allowed to perform such as providing preventive and therapeutic treatment by utilizing Interim Therapeutic Restorations in alternative settings and filling cavities in a dental practice. It seems to be questionable policy for a dentist, the most expensive and highest compensated person of the dental team, to spend his or her time doing procedures which are low risk and can be performed by a dental hygienist or an expanded function dental hygienist. Better utilization of both dental hygienists and dental assistants to their fullest professional capacity will result in more efficiency and quality of care.

A pilot project report from California Health Manpower Pilot Projects Program concluded that independent practices by dental hygienists: 1) provided access to dental care, satisfied customers, and encouraged visits to the dentist; 2) consistently attracted new patients, charged lower fees and preventive services were more available to Medicaid patients than they would be in a dental office; and

3) produced outcomes in both structural and process aspects of care that in many cases surpassed those available in dental offices in quality, achieved high patient satisfaction, and showed no increased risk to the health and safety of the public (*Journal of Public Health Dentistry*, 1997).

In an effort to increase capacity of dental services in Nebraska, the Nebraska Dental Assistants Association (NDAA) filed a 407 Application in 2008 to create three levels of dental assistants: 1) a Dental Aide (on the job trained dental assistant); 2) a Licensed Dental Assistant; and 3) an Expanded Function Dental Assistant. The application was opposed by the Nebraska Dental Association (NDA) and the Nebraska Dental Hygienists' Association (NDHA). The NDAA application did not receive a favorable opinion from the Nebraska Board of Health nor was the NDAA successful before the Nebraska Legislature.

While the NDHA opposed the NDAA application filed in 2008, the NDHA and the NDAA collaborated in 2009 in an effort to find consensus on the scope of practice for dental assistants. In 2010, the NDA elected instead to have legislation introduced that authorized the Board of Dentistry to adopt rules and regulations for the scope of practice for dental assistants, with or without education, and without a credential. Both the NDHA and NDAA opposed NDA's legislation. The legislation did not pass.

As a result of the NDA legislation being introduced, NDA, NDAA, and NDHA decided to form The Future of Teamwork in Dentistry Task Force. The task force acknowledged that it was better to work together to create a model that could be agreed upon by all three associations, addressed the professional requirements of the three associations, and would be responsive to the needs of Nebraskans to access dental care. The task force's goal was to endorse one model and move forth collaboratively through the 407 Process and the Legislative Process. The task force studied:

What might be the best possible way that dentists, hygienists, and assistants could work together in a manner that would offer the best quality of care possible to patients; better utilize the knowledge, skills, and existing workforce of hygienists and assistants; help dental practices and other clinics and programs that need to increase efficiency; and help the State of Nebraska through increasing access to care.

The task force also acknowledged that access to care is a very complex issue and simply expanding the scope of practice of dental hygienists and dental assistants is not a stand-alone solution to expanding access to dental care. Other factors that needed to be addressed include: addressing adequate water fluoridation; increasing availability of affordable dental insurance; addressing administrative and cultural barriers, including Medicaid reimbursement rates placing dentists in underserved counties and communities; and increasing oral health literacy.

The model presented in this proposal is reflective of the work of the group and what the Nebraska Dental Hygienists' Association supports. This proposal is a compilation of topics discussed by the task force over the last three years and what NDHA believes best addresses the needs of Nebraska. The model uses the existing workforce of dental hygienists and dental assistants and the existing education and accredited training programs available to both. The model allows those dentists who wish to delegate more to their clinical staff, the ability to do so. The model also allows dentists who wish to practice the status quo, not to change how they practice. The model aligns appropriate supervision with the delegated duties. The model preserves on-the-job training for dental assistants for those dentists practicing in areas of Nebraska where finding trained dental assistants is difficult. Finally, the model balances the need for education and

credentialing while at the same time not overly regulating any one profession. [The newly proposed model can be found in Appendices B and C.]

In summary, the proposed model is a responsible means for serving the Medicaid, underserved and unserved populations in Nebraska who may have difficulty finding dental care. The proposed model allows dental clinics to operate more efficiently, thus potentially increasing their capacity to care for more Medicaid, underserved and unserved populations. Finally, the proposed model is an expanded model of care that will more effectively and efficiently serve *all* Nebraskans who receive dental services.

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## **2. Groups Associated with this Proposal.**



<i>Groups/Entities Whom May be Associated with the Application</i>	<i>Name of Organization</i>	<i>Contact Info</i>
<b>Dental Profession</b>	Nebraska Dental Association	c/o David O'Doherty, Executive Director 7160 S. 29 <sup>th</sup> St., Ste #1 Lincoln, NE 68516 <a href="mailto:davidodoherty@windstream.net">davidodoherty@windstream.net</a> (402) 406-1704 <a href="http://www.nedental.org">www.nedental.org</a>
<b>Dental Hygiene Profession</b>	Nebraska Dental Hygienists' Association	Kathi Schildt, Executive Director 521 First Street PO Box 10 Milford, NE 68405 (402) 761-2216 <a href="mailto:kschildt@youraam.com">kschildt@youraam.com</a> <a href="http://www.nedha.org">www.nedha.org</a>
<b>Dental Assistants</b>	Nebraska Dental Assistants Association	President Nicole Berney, CDA, BA <a href="mailto:nberney@southeast.edu">nberney@southeast.edu</a> <a href="http://www.nebraskadentalassistants.org">http://www.nebraskadentalassistants.org</a>
<b>Education Programs for Dentists, Hygienists, and Assistants</b>	UNMC College of Dentistry	40 <sup>th</sup> and Holdrege St. Box 830740 Lincoln, NE 68583-0740 (402) 472-1301 <a href="http://www.unmc.edu/dentistry">www.unmc.edu/dentistry</a>
	Creighton University School of Dentistry	2802 Webster Street Omaha, NE 68178 (402)280-5890 <a href="http://www.creighton.edu/dentalschool">http://www.creighton.edu/dentalschool</a>
	UNMC College of Dentistry, Dental Hygiene Program	40th & Holdrege St. Lincoln, NE 68583-0740 (800) 626-8431 Program Director: Gwen Hlava
	CCC Dental Hygiene Program	P.O. Box 1024 Hastings, NE 68902-1024 (402) 461-2470 Program Director: Wanda Cloet
	Central Community College Dental Assisting Program	East Highway 6 P.O. Box 1024 Hastings, NE 68902-102 <a href="http://www.cccneb.edu">www.cccneb.edu</a> Program Director: Ms. Marie Desmarais Phone: 402-461-2467 <a href="mailto:mdesmarais@cccneb.edu">mdesmarais@cccneb.edu</a>
	Metropolitan Community College	P.O. Box 3777 Omaha, NE 68103-0777

	Dental Assisting Program	<a href="http://www.mccneb.edu">www.mccneb.edu</a> Program Director: Ms. Joan Trimpey Phone: 402-738-4675 <a href="mailto:jtrimpey@mccneb.edu">jtrimpey@mccneb.edu</a>
	SE Community College Dental Assisting Program	8800 'O' Street Lincoln, NE 68520-1299 <a href="http://www.southeast.edu">www.southeast.edu</a> Program Director: Ms. Crystal Stuhr Phone: 402-437-2740 <a href="mailto:cstuhr@southeast.edu">cstuhr@southeast.edu</a>
	Vatterott College, Omaha Campus	11818 "I" Street Omaha, NE 68137 <a href="http://www.vatterott.edu/omaha.asp">www.vatterott.edu/omaha.asp</a> Program Director: Ms. Roberta Worm Phone: 402-891-9411 x142 <a href="mailto:roberta.worm@vatterott.edu">roberta.worm@vatterott.edu</a>
	Kaplan University- Omaha Dental Assisting Program	Dental Assisting Program 5425 N. 103rd Street Omaha, NE 68134 <a href="http://www.kaplanuniversity.edu/omaha-nebraska.aspx">www.kaplanuniversity.edu/omaha-nebraska.aspx</a> Program Director: Ms. Shannon Roen Phone: 402-431-6185 <a href="mailto:sroen@kaplan.edu">sroen@kaplan.edu</a>
	Mid-Plains Community College Dental Assisting Program	1101 Halligan Drive North Platte, NE 69101 <a href="http://www.mpcc.edu">www.mpcc.edu</a> Program Director: Ms. Lauri Rickley Phone: 308-535-3650 <a href="mailto:Rickleyl@mpcc.edu">Rickleyl@mpcc.edu</a>
<b>Other Non-Dental Related Groups with Interest in Proposal</b>	Nebraska Pharmacists Association	6221 S 58th Street, Suite A Lincoln, Nebraska 68516 Phone: 402-420-1500 Fax: 402-420-1406 <a href="mailto:info@npharm.org">info@npharm.org</a>
	Nebraska Health Care Association	1200 Libra Drive, Suite 100 Lincoln, NE 68512 Phone 402-435-3551 Fax 402-475-6289 <a href="mailto:nhca@nehca.org">nhca@nehca.org</a>
	Nebraska Hospital Association	3255 Salt Creek Circle, Suite 100 Lincoln, NE 68504-4778 Phone (402) 742-8140 Fax (402) 742-8191
	Nebraska Nurses Association	PO Box 82086 Lincoln, NE 68501

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	Nebraska Rural Health Association	John Roberts 2222 Stone Creek Loop South Lincoln, NE 68512 (402) 421-2356 phone (402) 421-2356 fax Email: <a href="mailto:jroberts@mwhc-inc.com">jroberts@mwhc-inc.com</a>
	Public Health Association of Nebraska	Rita Parris, Executive Director <a href="mailto:PublicHealthNe@cs.com">PublicHealthNe@cs.com</a> 1321 South 37th Street Lincoln, NE 68510 Phone - 402.483.1039 Fax - 402.483.0570
	Nebraska Head Start Association	Suzan Obermiller, President PO Box 509 Loup City, NE 68853 <a href="mailto:sobermiller@cennecs.org">sobermiller@cennecs.org</a> Tel: 308/745-0780
	One World Community Health Center	Andrea Skolkin, Chief Ex. Officer 4920 S. 30 <sup>th</sup> St. Suite 103 Omaha, NE 68107 402-502-8842 <a href="mailto:askolkin@oneworldomaha.org">askolkin@oneworldomaha.org</a>
	Health Center Association of Nebraska (HCAN)	Nancy Thompson, CEO 3929 S. 147 <sup>th</sup> St. Altech Plaza, Suite 100 A Omaha, NE 68144-5529 402-932-3132 <a href="mailto:nthompson@HCANebraska.org">nthompson@HCANebraska.org</a>
	Nebraska School Nurses Association	Tonja Frank RN North Bend Central Public Schools 1430 Walnut Street North Bend, NE 68649 Direct Line: 402-637-8087 Email: <a href="mailto:president@nebraskaschoolnurses.com">president@nebraskaschoolnurses.com</a>
	Nebraska Association of Nurse Anesthetists	Ron Jensen 625 S. 14 <sup>th</sup> St.—Suite A Lincoln, NE 68508 402-436-2165 <a href="mailto:ron@jensenrogert.com">ron@jensenrogert.com</a>

**3. Current scope of the dental hygiene profession in Nebraska. Identify proposed change in scope.**

Dental hygienists are licensed oral health professionals who focus on assessing, preventing and treating oral diseases in order to protect teeth and gums, and also protect patients' total health. Dental hygienists provide patient care under the general supervision of licensed dentists. Public Health Registered Dental Hygienists provide a limited scope of services in public health settings and health care facilities without the supervision of a dentist. [See Appendix D.]

The changes requested for the dental hygiene profession include an expansion of scope under general supervision which allows the dental hygienist to provide the entire Registered Dental Hygienist scope of practice without the dentist on the premises. Expansion of the Public Health Dental Hygienist (PHDH) would increase the services allowed under this permit while maintaining the infrastructure of a public health setting or health care facility. A new Expanded Function Registered Dental Hygienist (EFRDH) level would be created. The EFRDH would place and finish restorations and extract primary teeth under the general supervision of a dentist within a dental practice. [See Appendix C.]

#### **4. Current scope of practice of dental assistants in Nebraska and the proposed changes.**

As defined by Neb. Rev. Stat. §38-1107, a dental assistant means "a person, other than a dental hygienist, employed by a licensed dentist for the purpose of assisting such dentist in the performance of his or her clinical and clinical-related duties."

Dental assistants are allowed to:

1. Assist a dentist in the administration of general anesthesia, parenteral sedation, or inhalation analgesia if they are certified in basic life-support skills or the equivalent thereof (Neb. Rev. Stat. §38-1143).
2. Perform coronal polishing with education and training (172 Neb. Admin. Code, ch. 53, § 005, et al.).
3. Take Roentgenograms (x-rays) with education and training (172 Neb. Admin. Code, ch. 53, § 004).

Two levels of dental assistant would be defined: 1) dental assistant; and 2) licensed dental assistant. The changes requested for dental assistants include: defining duties; directing educational requirements, clarifying levels of supervision; providing credentialing that will create accountability to ensure the safety and protection of the public. [See Appendix B.]

#### **5. Functions typically performed by Nebraska dental hygienists and dental assistants and their current limitations.**

a) Functions typically performed by dental hygienists

The following are typically performed by hygienists: oral health care assessments that include the review of health history, dental charting, oral cancer screening, hard tissue assessment, and evaluation of gum disease / health; expose, process, and interpret dental x-rays; remove plaque and calculus (tartar) from above and below the gumline using dental instruments; including scaling and root planning/ non-surgical periodontal therapy; apply cavity-preventive agents such as fluorides and sealants to the teeth and subgingival agents to treat periodontal disease; administer local anesthetic; educate patients on proper oral hygiene techniques to maintain healthy teeth and gums; counsel patients about plaque control and developing individualized at-home oral hygiene programs; smoking cessation programs; and counsel patients on the importance of good nutrition for maintaining optimal oral health.

Statutory limitations placed on services include: the performance of irreversible procedures; indirect supervision of local anesthetic administration; placing chemotherapeutic agents; and monitoring of nitrous oxide.

b) Functions typically performed by dental assistants

Currently dental assistants perform duties as delegated to them by a dentist. This varies greatly from office to office and differs in specialty practices. Typically, dental assistants in all practice settings prepare the room for treatment, seat patients, and perform all disinfection and sterilization procedures. Dental assistants may: mix and pass materials; suction; make and cement temporary restorations; take preliminary impressions; perform lab work as needed; and, if they complete a course, take x-rays and polish teeth (Guidelines taken from the *Position Paper of the ADAA/DANB Alliance: Address A Uniform National Model For The Dental Assisting Profession*, September, 2005).

**6. Occupations that perform some of the same function or similar functions.**

Dental hygienists can do any function that dental assistants can do. Otherwise, there is relatively no overlap with other professions or groups.

**7. Functions unique to dental hygiene and dental assisting.**

Please reference Question 5. While dental hygienists may perform the duties of a dental assistant, in most cases the dental hygienist focus is on preventive dental services and the dental assistant focus is on restorative dental services. Dental assistants in specialty or general practices assist with endodontics, prosthodontics, oral surgery, orthodontics, general dentistry and more, on a wide variety of patients of all ages.

Dental hygienists is permitted to work independently of a dentist if they are a public health registered dental hygienist and practicing in public health settings, can do below the gum cleaning, and can place sealants. Dental hygienists provide comprehensive assessments, remove hard deposits from above and below the gum line, give local anesthetics, and place sealants. They are prohibited from placing local anesthesia without the presence of a dentist. Dental hygienists may also perform the prophylaxis (cleaning) procedure that improves the health of the soft tissue resulting in reduced inflammation. This has a positive impact on the systemic health of patients served, especially those at risk for diabetes, heart disease, stroke, and aspiration pneumonia.

## **8. Occupations who typically supervise hygienists and assistants.**

Dentists always supervise dental assistants when working together. Dental hygienists are currently supervised to some degree by dentists in private practice settings and may or may not be supervised by a dentist in public health settings. In public health settings, such as school-based sealant programs, dental hygienists may be supervising dental assistants.

## **9. What procedures can be carried out without supervision or orders? How autonomous is each group?**

### **a) Dental Hygienists**

Registered dental hygienists work under the general supervision of a dentist, but do have autonomy if they are a public health registered dental hygienist (PHRDH). General supervision means the directing of the authorized activities of a dental hygienist or dental assistant by a licensed dentist and shall not be construed to require the physical presence of the supervisor when directing such activities.

The PHRDH works within the infrastructure of a public health setting or health care facility. Orders from a dentist are not required to provide services; however, the infrastructure provides a level of oversight, peer review and inspection. PHRDH report to DHHS through the State Dental Director and/or his or her designee. PHRDH also carry their own liability insurance.

b) Dental Assistants

Dental assistants are not autonomous and have no duties designated without supervision. Duties are currently performed under either indirect or general supervision. Indirect means that the dentist is on the premises. Some duties are routinely performed under general supervision, meaning the dentist is not on the premise. Examples of such are any non- patient contact duties, as well as taking x-rays, preliminary impressions, and fluoride treatments.

**10. How many people are performing dental assisting and dental hygiene procedures in Nebraska? To what extent are they credentialed?**

a) Dental Hygienists

Currently there are 1261 registered dental hygienists licensed in Nebraska and 103 dental hygienists holding a Public Health Permit. All dental hygienists are credentialed by licensure.

b) Dental Assistants

Dental assistants are not credentialed in the state of Nebraska and, therefore, there are no official lists (e.g., registration, certification or license lists) to identify that number. However, according to *The 2005 Nebraska Workforce Needs Report*, the 351 responding dentists employed 1690 assistants, 4.8 dental assistants per dentist. According to a 2008 survey of dental practices by the ADA Survey Center, from 2003 to 2007, the average number of dental assistants per dentist in the primary private practice of independent dentists averaged 1.6 dental assistants per dentist. Specialists during that same time employed an average of 2.6 dental assistants. Nebraska has approximately 1000 actively licensed dentists. Using these formulas, there would be approximately 2000-4800 full and part-time dental assistants working in Nebraska.

**11. Level of education and how are members educated in Nebraska?**

a) Dental Hygienists

Dental Hygienists are graduates of accredited dental hygiene education programs at the college and university level. They have at a minimum an associate degree, which means those whom graduate from these programs received didactic and clinical experiences from calibrated faculty. Educational programs also provide for rotations in a variety of settings including schools, nursing homes, and hospitals. Dental hygienists must take written national board examination, a clinical examination, and jurisprudence test before they are licensed to practice. [See Appendix D.]

b) Dental Assistants

Nebraska does not mandate any educational prerequisites for dental assistants. Dental assistants receive on-the-job training. *The 2005 Dentistry Staffing & Education Needs Report* by Nebraska Workforce Development showed that of those who responded, 46 percent of dental assistants were trained on-the-job.

Some dental assistants have voluntarily attended American Dental Association - Commission on Dental Accreditation (CODA) programs.<sup>1</sup> There are numerous programs nationwide and six (6) in Nebraska. These programs are a minimum of one year in length and require a minimum of 300 hours of supervised internship.

Dental Assisting National Boards (DANB) is a nationwide testing agency for dental assistants. While not required in Nebraska, dental assistants have voluntarily taken the DANB exams (e.g., radiation, infection control and chairside assisting) and maintained the credential of Certified Dental Assistant (CDA). As of March 1, 2013, there were 331 CDA's in Nebraska.

## **12. Work settings.**

a) Dental Hygienists

The majority of dental hygienists work in private practice as employees of dentists while Public Health Registered Dental Hygienists practice in hospitals, clinics, nursing homes, schools, and other public health settings. In addition to treating patients directly, dental hygienists may also work as educators, researchers, and administrators.

b) Dental Assistants

Dental assistants work in a variety of settings, including private and specialty dental practices, dental clinics, dental laboratories, public health clinics, out-patient surgical facilities, government clinics, educational institutions, military, insurance companies,

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<sup>1</sup> Link to CODA standards for dental assistants:

[http://www.ada.org/~media/ADA/Education%20and%20Careers/Files/da\\_2014.ashx](http://www.ada.org/~media/ADA/Education%20and%20Careers/Files/da_2014.ashx)



and dental supply/product companies. The predominant setting for dental assistants is in private dental practices.

### **13. Do hygienists and assistants serve the general population?**

Both dental hygienists and dental assistants serve the general population.

### **14. Reasons someone would seek services of hygienists and assistants**

Most Nebraskans seek “dental care” as opposed to seeking services by a specific type of dental care provider. However, in a public health setting, school nurses or other public health professionals would seek the services of dental hygienists to work with their respective populations. For example, a school nurse might ask a dental hygienist to screen school children and/or place dental sealants.

A dental hygienist is a primary care oral health professional who has graduated from an accredited dental hygiene program in an institution of higher education and is licensed in dental hygiene to provide education, assessment, research, administrative, diagnostic, preventive and therapeutic services that support overall health through the promotion of optimal oral health. There are many areas of coordinated care that a dental hygienist is an appropriate choice to include in a patient’s overall health care.

### **15. Typical referral patterns.**

Since 95 percent of dental hygienists and dental assistants work in conjunction with a dentist, it is typically the dentist who refers patients to specialists, physicians, or others. However, a dental hygienist working in a public health setting would be the one to refer a patient to a dentist or other health care providers as required.

### **16. Is a prescription/order from another (assuming dentist) necessary for services to be provided?**

In current statute, a dental assistant is directed by a dentist to perform a procedure. Currently, a dental hygienist would not need an order for a dental screening, x-rays, cleaning, fluoride, or sealants, but would need an order to monitor nitrous oxide.

In the new proposal, a licensed dental assistant would still be required to receive direction before performing more advanced procedures. A dental hygienist would not

need an order for basic duties (cleaning teeth, taking radiographs) or the new duties of writing a prescription for fluoride products or antibacterial mouth rinses. He/she would need an order to restore a tooth (e.g., with a filling, or stainless steel crown on a baby tooth) after the dentist has removed the decay. An order from a DDS or MD would also be required to remove a hopeless and extremely loose permanent tooth in a nursing home setting or extracting a primary tooth in a private practice or public health setting.

A dental hygienist does not need an order to commence Interim Therapeutic Restoration (ITR) or Atraumatic Restorative Technique (ART). These are procedures used when it is more appropriate to stabilize tooth decay in a patient where age, how soon they would lose the tooth, behavior, terminal illness, or other circumstances make a less invasive, traditional “drill and fill” treatment contra indicated. An example would be when a dental hygienist is in a nursing home and evaluates a patient that has minor tooth decay on a front tooth but the individual is limited to their bed and no dentist with traditional dental equipment is caring for that patient. The hygienist would scoop out the soft decay and fill the void with a tooth colored filling that is done primarily with a hand instrument. This technique is approved by the American Dental Association, American Academy of Pediatric Dentistry and the World Health Organization. The goal is to “buy time” and stabilize active dental caries (tooth decay) disease until either the patient can seek more definitive treatment or the tooth is lost.

## **17. How is continuing competence of credentialed practitioners evaluated?**

Dental hygienists as an already credentialed profession would continue to seek continuing education (CE) based on current statute as is consistent with the Uniform Credentialing Act. If dental hygienists are providing expanded duties, they would likely choose CE in this area. This is consistent with how dentists acquire CE. Dentists are required to have 30 hours of CE every two years and are not required to have a certain number of hours in specific procedures.

There are no required written or clinic tests for general dentists, dental hygienists, or dental assistants to measure continuing competence. Dentists who are board certified in a specialty undergo testing based on their specialty board organizations’ guidelines. Therefore, the proposal does not require additional testing after initial licensure for dental hygienists and dental assistants.

The new tier proposed for dental assistants would require licensure. As is consistent with dentists and dental hygienists, this level of dental assisting would also require 30 hours of CE every two years. The Dental Assisting National Board (DANB) also has a testing system that states can use to license dental assistants.

Overall, because the majority of new procedures for dental assistants will require the direct supervision of the dentist, the dentist must assure the competency of his/her

staff that will assure reasonable safety and quality of care. The intent is that the dentist is assuring that all care provided within his/her practice or clinic setting is done to the standard of care and the dentist is ultimately responsible for the patient's dental care. This is consistent with other states' statutes that have similar models of care delivery. In addition, when a patient and/or other dental professional believes that the treatment provided was below the standard of care, this can be handled through the current peer review system and/or the judicial system.

Currently, there is no requirement for initial or continuing competence of a dental assistant. Under the proposal:

1. The licensed dental assistants would be subject to the Uniform Credentialing Act and need 30 hours of continuing education every 2 years for license renewal.
2. The dentist employer would be continuously monitoring the quality of the functions performed by the dental assistant as he/she shares in the responsibility for the quality of services performed.
3. Disciplinary action by the Nebraska Board of Dentistry would be responsible for restricting or suspending incompetent practitioners.

## **18. What requirements must they meet before credentials are renewed?**

All levels of dental hygiene and the second level of dental assisting will require 30 hours of continuing education (CE) every two years in addition to the fees and paperwork requirements outlined in the Uniform Credentialing Act (UCA).

Dental hygienists are required to have 30 hours of CE every two years for license renewal. The UCA and Health and Human Services Rules and Regulations outline the types of activities allowed for license renewal. Commonly dental hygienists will attend CE programs sponsored by professional organizations and colleges. Testing is NOT required for CE programs. Home study and online courses may be utilized with testing required.

## **19. Identify other jurisdictions wherein this occupation is currently regulated by government and the scopes of practice typical.**

Dental hygienists are licensed in all 50 states. Thirty-six (36) states have direct access permits; 18 states allow dental hygienists to place, carve and finish restorations; and 3 states have expanded the education of dental hygienists to include preparation of the tooth for routine restorations. Legislation that allows for patient care models that expand mid-level provider has been introduced in states across the country.

Dental assistants are regulated on a state-by-state basis with varying degrees of allowable duties and corresponding education and competency testing.

## Additional Questions

### 1. What is the problem created by not regulating the health professional group under review or by not changing the scope of practice of the professional group under review?

The problem created by not changing the scope of practice for dental hygienists is that Nebraska will fall further behind in providing dental care to the underserved and unserved populations.

The problem created by not regulating dental assistants is that the state of Nebraska will miss an opportunity to clarify the current confusion of the scope of practice of a dental assistant. The problem by not changing the scope of practice of dental assistants is that the state of Nebraska will miss an opportunity to expand the potential to provide dental care to the underserved and unserved populations. In sum, such a change assures competency and more effectively protects the health of safety of the public.

#### a) Increased risk of potential for harm without regulation

In the recommended proposal, dental assistants are providing more patient care. Many functions that are delegated to assistants are billable, insurance coded services. The expansion of functions has not been accompanied by any increase in training, continuing education, competency testing or credentialing. Dental assistants without proper education, testing and credentialing pose a danger to the public from a lack of knowledge and competency testing.

#### b) Inconsistency without regulation

As no list of duties or associated levels of supervision exists in either statute or rules and regulations, it is currently unclear to the patient, supervising dentist and the dental assistant as to which functions the dental assistant may perform, leading to a wide range of interpretations and inconsistent levels of training and supervision for dental assisting functions throughout the state. All dental functions have some inherent risk of danger or harm if used improperly. If it is deemed necessary that dentists and dental hygienists have formal education, testing and credentialing to perform services, then the dental assistant should also have some level of credentialing to perform services.

#### c) No Mechanism to discipline members of the group without regulation

Without regulation there is no mechanism to discipline dental assistants. Currently, only the dentist employer can be disciplined.

## **2. Evaluate the feasibility of applying the following to the profession and the extent to which the regulatory method would protect the public.**

### **a) Inspection requirements**

None. Because the majority of the newly proposed scope of hygiene practice and all the newly proposed scope of dental assisting practice falls under the practices and clinics operated by dentists and public health institutes, inspection is completed as is consistent with the rules and regulations of the practice of dentistry. No mechanism is currently in place to inspect all facilities in the state where dental services are performed and this would be cost prohibitive to initiate and maintain.

### **b) Injunctive relief**

The same system would be in place for the awarding of damages should a patient feel they were harmed or not provided with quality care. However, due to the typical situation of the dentist having the “deeper pockets,” this threat holds the dentist accountable for the care provided by their staff. Dental hygienists do carry malpractice insurance. To regulate dental assistants on a case-by-case basis in the court system would be costly and not serve to adequately protect the public, only compensate.

### **c) Regulating the business enterprise rather than individual providers**

None. The new scope of duties being proposed is primarily within a dental practice where the dentist is the owner of the practice. In cases where a dental hygienist is contracting with a public health clinic or other such entity, payment of his/her services are spelled out in the contract or billed directly to Medicaid.

### **d) Regulating or modifying the regulation of the dentists**

None. Dentists are already regulated through the Dental Practice Act and accompanying rules and regulations. Ultimately, the dentist is responsible for all patient care that is provided in his/her clinic regardless who provides the care. The dentist will continue to have a vested interest in assuring quality of care or patients will find another dental care provider. The proposal would enhance the dentist’s ability to administer and may also lessen the exposure to liability because the proposal provides the dentist with a more specific list of duties and the required level of education and supervision. All of which is currently lacking.

### **e) Registering the providers under review**

None.

### **f) Certifying the providers under review**

This proposal is not seeking to certify any of providers under review. The proposal seeks to license them. Certification is a voluntary credential and would not protect the public.

g) Licensing the providers under review

By licensing dental assistants, the public is assured an increased level of protection through the completion of mandated education, the requirement to apply for a license, and the requirement of obtaining continuing education.

**3. What is the benefit to the public of regulating the groups under review or changing their scope of practice?**

The American Dental Hygienists' Association (ADHA) states that when dental hygienists are educated and licensed, they are competent and prepared to practice at the top of their scope without supervision (Ann Lynch, Governmental Affairs).

The National Governors Association Report, *The Role of Dental Hygienists in Providing Access to Oral Health Care* (January 6, 2014)<sup>2</sup> states: "As states face more demand for oral health, they should examine the role that dental hygienists can play in increasing access to care by allowing them to practice to the full extent of their education and training."

The Federal Trade Commission (FTC) comments to the report contended that there was no evidence that allowing dental hygienists to provide preventive services without supervision was a safety issue. The FTC further contended that restricting the practice without evidence that the restriction limits public safety unnecessarily reduces competition. The FTC also weighed in with a 15-page letter in regard to dental therapy standards proposed by Commission on Dental Accreditation (CODA).<sup>3</sup> The FTC notes "that proposed dental therapy standards effectiveness may be limited by unnecessary statements on supervision, evaluation and treatment planning...Conversely, if competition is hindered by laws that reserve the provision of even simpler services to more highly trained professionals, access may be compromised and cost savings may be inhibited" (Federal Trade Commission, December 2, 2013).

Currently, some subgroups of Nebraska's population have difficulty accessing dental care. These populations tend to include poor children and very young children, typically under 5 years old; persons living in counties that do not have a dentist; uninsured poor adults; developmentally disabled adults; and counties where there is no dentist seeing new Medicaid-eligible patients.

Approximately, one-third of Nebraska's dentists see Medicaid and a smaller percent see Medicaid-eligible patients (i.e., no more than a few patients per month). Research on a national level has shown this is a multi-factorial problem related to poor oral health literacy, administrative barriers, low reimbursement, and other factors that make

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<sup>2</sup> <http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf>

<sup>3</sup> This "dental therapy" scope would be similar to what Nebraska is considering for the Expanded Function Dental Hygienist.

visiting a dentist difficult for those who may have, for example, smaller incomes, and transportation issues.

However, many dental practices have been able to overcome these challenges and are able to see meaningful number of Medicaid-eligibles. Still though, reimbursement rates of the Dental Medicaid Program have put increasing pressures on practices to see fewer Medicaid patients. By increasing the efficiency of the practice, through better delegation of duties, the same quality of care can be provided at a lower cost. It is much more cost-efficient for a dentist to be diagnosing and providing surgical treatment and irreversible procedures than it is to be doing simpler procedures. One could argue that a well-trained EFRDH might even provide a higher level of care when his/her scope is limited to a handful of things they do very well.

According to Domer (2005), he found that in Colorado, when high delegation dentists were asked how delegation had affected their practice, they answered they believed that expanded delegation had: 1) increased the numbers of patients seen; 2) increased productivity and income; 3) reduced stress of practicing dentistry; and 4) produced reduced hours without a decrease in practice income.

Often it is the dental hygienists who spend more time with the patients. Furthermore, the dentist may unexpectedly be delayed in a longer procedure. These new models offer practices and their dental staff team greater flexibility in caring for patients, while continuing to allow the dentist to administer and manage his/her practice.

Medicine is decades ahead of dentistry in delegating the more simple and safest procedures. Nurse practitioners and physician assistants have long been able to extend the reach of physicians in order to provide care to populations in need. Most rural clinics would not be able to remain open if it were not for these “mid-level” providers.

The benefit to the public is that more members of the dental team can perform more functions. If one is a member of a sub-group of the population that typically has difficulty getting timely access to dental care, this proposal will help. The goal is to make more efficient use of the dental team. Efficiency is key in order to recruit and retain dentists who see Medicaid-eligible patients. Also expanding the reach of public health dental hygienists is a huge factor since the majority of underserved people with the majority of dental disease do not take advantage of the traditional dental care delivery system (*Paul Glassman DDS, MA, MBA, 2014*).

According to the *Health Professional Shortage Areas Nebraska 2013 Report*, there are 43 of the 93 counties marked as designated State Dental Shortage Areas, with an additional 6 more counties with partial shortage areas. This shortage of dentists will limit the amount of patient contact time. By allowing dental hygienists and dental assistants to perform more functions after completing the recommended educational requirements, it will help to reduce, in part, the manpower shortage and increase the productivity of the dental office. Many patients must travel to other counties for dental treatment.



With the creation of a licensed dental assistant and expanding the scope of dental hygienists, the availability of treatment will increase.

**4. What is the extent to which the proposed change in scope would harm the public?**

The applicant group does not believe there is any evidence that supports licensed dental assistants or expanded function dental hygienists causing harm to the public. However, there is always a small risk that dentists that potentially use these models of care to over-treat patients or choose not to appropriately supervise them. The Nebraska Dental Board already has a system in place to address issues of scope of practice and inappropriate supervision. In fact, by clarifying these duties, it will actually clarify much of the current statutory language that is vague and open to interpretation, which will ultimately provide greater protection to the public.

Currently there is much confusion over whether it is legal for a dental assistant to place a sealant today. The Board of Dentistry and Attorney General have issued conflicting opinions on this as well as the authority of the Board of Dentistry to mandate education for dental assistants in the past. While the Board of Dentistry has through rule and regulation mandated education for dental assistants for coronal polishing, the Nebraska Attorney General issued an opinion that the Board of Dentistry cannot mandate educational requirements for dental assistants, because they are not currently licensed.

The Medicaid Fraud Division of the Office of the Attorney General will also provide oversight and protect the public. A dentist who was billing incorrectly or over-billing would be investigated with delegation duties being strictly scrutinized.

In sum, the applicant does not believe there is any evidence that supports licensed dental assistants or dental hygienists have caused harm to the public. Several studies have been done to support this. *A Comparison of Dental Restoration Outcome After Placement by Restorative Function Auxiliaries Versus Dentists*, "published in the Spring 2012 Journal of Public Health Dentistry, concluded that, "[t]here was no significant difference in problem rates for restorations placed by expanded function auxiliary versus those placed by dentists. This finding may free dentists to handle more difficult cases, alleviating some of the pressures of daily practice and meeting the need for improved access."

**5. What standards exist or are proposed to ensure that a practitioner of the groups under review would maintain competency?**

Dental hygienists, as a licensed profession, must maintain 30 hours of continuing education every two years. This is the same for dentists. The proposal would require 30 hours every two years for dental assistants who become licensed. Other than

examination for initial licensure, there are no testing requirements for either dentists or hygienists, and the applicant is not proposing the necessity of testing in this application. The American Dental Association is the organization that is currently studying what type of testing is appropriate for continued competency of dentists. The applicant would expect when the dental profession adopts new standards, it would be likely that something similar would be required of licensed dental hygienists and licensed dental assistants.

**6. What is the current and proposed role and availability of third-party reimbursement for the services provide by the groups under review?**

Dental assistants would not be eligible for any third-party payments since they work under the supervision of the dentist who is the one reimbursed. Dental hygienists are primarily paid through the dental practice they work for (on an hourly rate). However, for procedures they can bill Medicaid for when working in public health settings, they would bill Medicaid either directly or the contractor would bill Medicaid. Currently, a number of dental insurance plans and dental service corporations pay claims for services provided by dental hygienists. Dental hygienists are identified on all electronic submissions by a national provider number (NPI) and a healthcare provider taxonomy code (124Q00000X) as required by the Health Insurance Portability and Accountability Act of 1996. State Insurance laws have a provider nondiscrimination clause which generally means that a plan offering dental benefits cannot discriminate with respect to participation of any provider acting within their scope of practice.

**7. What is the experience of other states in regulating the practitioners affected by the proposal? Identify appropriate statistics on complaints, describing actions taken, etc., by states where the profession is regulated.**

Restorative hygiene was instituted in Washington in 1971. Since then, no disciplinary issues have been brought before the Washington State Department of Health related to the placement of restorations by dental hygienists according to Colleen Gaylord, Chairman of the Regulation and Practice Committee of the Washington Dental Hygienists' Association. A high level of confidence persists in the skill and training of the state's dental hygienists.

*The Dental Workforce Study (2001)*, commissioned by the Washington State Dental Association, found that approximately 28 percent of the state's dental hygienists in private practice performed restorative care functions, typically for five to nine hours per month. Because dental hygienists are universally prohibited from cutting hard tissue, restorative hygienists work in partnership with a supervising dentist, completing the

restoration after the tooth is initially prepared. By utilizing the restorative endorsement, restorative dental hygienists provide therapeutic services that enhance their value to the dental team.

In 2003, the Minnesota State Legislature revised the Dental Practice Act to allow allied dental personnel (dental assistants and dental hygienists) to expand their scope of practice to include placement of restorative materials (e.g., amalgam, glass ionomer, composite and stainless steel crowns). Placement of composite restorations was limited to Class I and V restorations in the enamel. Allied dental professionals certified in restorative functions (RF) are required to perform these functions under the direct supervision of a licensed dentist. This means that a dentist is present in the office, personally diagnoses the condition to be treated, and authorizes the procedure. At the time of this study, 387 allied dental personnel in Minnesota were certified to perform RF.

The concept of expanding the functions of dental assistants and dental hygienists is not new. Studies from the 1960s and 1970s indicated that both reversible and irreversible restorative procedures could be performed effectively, efficiently and at a cost benefit. In the 1980s, evaluations of expanded function dental assistants and dental hygienists from two demonstration projects in private general practice confirmed there were no meaningful differences in overall dental quality of restorations when compared to those placed by dentists. Worley, et al., recently found similar results for RF practitioners in Minnesota. A study of delegation of procedures on dental practices in Colorado revealed that as the rate of delegation increased, practices substantially increased their ability to see more patients and generate higher net incomes. Solo dental practitioners in general practices realized the largest gains in productivity and revenue with increases as great as 104 percent. Such findings demonstrate the potential that expanding the functions of the current dental workforce can have on the ability of dental practices to treat more patients. Increased productivity may allow practices to meet the growing demand for dental care due to Medicaid reform and implementation of the Affordable Care Act.<sup>4</sup>

*A Qualitative Study of Extended Care Permit Dental Hygienists in Kansas*, by Janette Delinger, RDH, MSDH, FAADH; Cynthia C. Gadbury-Amyot, MS, EdD; Tanya Villalpando Mitchell, RDH, MS; and Karen B. Williams, PhD, RDH, showed findings that the Extended Care Permit hygienists are making an impact with underserved populations, primarily children, the elderly and special needs patients. There are currently 35 states that allow some form of restorative functions for dental hygienists, and 29 states that allow for Nitrous Oxide administration.

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<sup>4</sup> Use of Restorative Procedures by Allied Dental Health Professionals in Minnesota, Jennifer J. Post, MDH, Adjunct Assistant Professor, Department of Primary Care, School of Dentistry, University of Minnesota and Jill L. Stoltenberg, MA, Associate Professor, Department of Primary Care, School of Dentistry, University of Minnesota

Innovative ways of delivering dental care are emerging to reach traditionally underserved populations. One strategy practiced in more than 50 nations is to authorize mid-level dental providers—often called dental therapists—to provide routine preventive and restorative care, such as placing fillings. Compared to dentists, dental therapists perform fewer procedures, require less training, and command lower salaries. Research has confirmed that they provide high-quality, cost-effective routine care and improve access to treatment in parts of the country where dentists are scarce. Mid-level providers are currently practicing in Alaska and Minnesota, were recently authorized in Maine, and are being considered for licensing in 15 additional states.

Dental therapists have been legally practicing in Canada for more than 40 years. All dental therapists in Canada have been educated in a 2 calendar year (20 month program nearing 3 academic years) program. Dental therapists in many other countries are increasing access to care and are valued members of the oral health care team.

A review of curriculum at the National School of Dental Therapy in Prince Albert, Canada in 2001 by Dr. Jim Tynan with the College of Dentistry at the University of Saskatchewan concluded:

"[T]hat dental therapy students far exceed the numbers of procedures performed by dental students in all relevant categories, both pre-clinically and clinically...[T]he expectations of [dental therapy] students are much more explicitly defined, both in terms of level of performance and number of procedures which must be achieved prior to students being permitted to provide patient care...In comparing dental therapy students to dental students regarding the specific restorative procedures that dental therapists are trained to perform, the conclusion is that dental therapy students are evaluated according to equivalent qualitative standards while surpassing the quantitative standards of dental students..."

Evidence clearly shows that dental therapists are well qualified to provide services within their limited scope of practice. No dental therapist has ever been cited for professional incompetence even though we have been working collaboratively with dentists in private and public health settings for over 40 years. In our history, no issue of professional liability has ever been raised about a dental therapist's practice or competence."

Evidence should guide this discussion versus just voicing unsupported opposition to expanding the scope of services provided by dental hygienists and dental assistants. Research studies demonstrate that these mid-level providers increase access and provide high quality care within their scope of practice. An analysis by the Pew Center also suggests that most private practice dentists could serve more patients while

maintaining or improving their bottom line by hiring an allied dental provider. Advocates in about a dozen states including Kansas, New Mexico, Ohio, Vermont, and Washington are working to develop proposals with models to expand their dental workforce.

**8. What are the expected costs of regulating the groups under review, including the impact of certification and licensure on the costs of services to the public? What are expected costs to the state and public of implementing the proposed legislation?**

There is no expectation that the public would share in the costs to license these new groups except for tax payer support of public university and community colleges that receive state funding for higher education. The Nebraska Department of Health and Human Services (DHHS)–Licensure Unit will apply application fees that are similar to what other groups pay for processing a license application. These would be covered by the professional being licensed.

Fees for licensure would be recommended by the Board of Dentistry and collected by DHHS-Licensure Unit. Fees could be set to ensure that costs are covered. Since this mechanism is in place for dentists and dental hygienists, the additional licensing of dental assistants should not unnecessarily overburden the current licensing process. It is anticipated that the number of dental assistants to license would begin with a small number and grow, representing a small percentage of the total dental assistants in the state. We believe this trend in Nebraska will start slowly and gradually increase over a period of years.

**9. Is there any additional info that would be useful to the TRC in their review of the proposal?**

Yes. It is important to note that just because the applicant is requesting an increased scope of practice for dental hygienists and creation of a scope of practice and licensure for dental assistants, many dentists will continue to practice using their dental team members in traditional roles. It is also important to note that this proposal will enhance existing dental practices that have highly qualified and experienced staff and that sees a large percent of Medicaid-eligible patients, because it proposes a model that if applied to operate more efficiently. The proposal also allows public health registered dental hygienists to increase their reach to provide more therapeutic procedures to the underserved and unserved populations in Nebraska.

### **ADA Definitions of Supervision**

*(Note that most states' definitions of supervision are not identical to ADA's definitions, though they are likely to be similar)*

**Personal supervision.** A type of supervision in which the dentist is personally operating on a patient and authorizes the allied dental personnel to aid treatment by concurrently performing a supportive procedure.

**Direct supervision.** A type of supervision in which a dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and, before dismissal of the patient, evaluates the performance of the allied dental personnel.

**Indirect supervision.** A type of supervision in which a dentist is in the dental office or treatment facility, has personally diagnosed the condition to be treated, authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and will evaluate the performance of the allied dental personnel.

**General supervision.** A type of supervision in which a dentist is not required to be in the dental office or treatment facility when procedures are provided, but has personally diagnosed the condition to be treated, has personally authorized the procedures, and will evaluate the performance of the allied dental personnel.

**Public Health Supervision.** That oversight where a licensed dental hygienist may provide dental hygiene services, as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings, as designated by state law, and with general oversight of such programs by a licensed dentist designated by the state.

## Proposal for Change in Levels of Nebraska Dental Assisting

**Functions Not Permitted:** Exam, Diagnosis, Treatment Planning, Surgical Procedures (including removal of tooth structure), Prescribing Drugs, Local Anesthesia, Scaling and Root planing (removing hard deposits on teeth). **Red**= new duty, rule, or requirement.

Level of Dental Assisting	Requirements/Recommendations	<b>Direct Supervision</b> (Dentist onsite, authorizes procedure/evaluates)	<b>Indirect Super vision</b> (Dentist on-site, and has authorized procedure)
Dental Assistant	<b>19 y/o</b>  Infection control training (per federal OSHA requirement)  CPR required  May be OJT or grad of community college program	Current duties as outlined in state rules/regs  <b>Monitor nitrous oxide (CPR certification required) and basic course in monitoring nitrous oxide similar to what an RDH takes.</b>	Current duties per state rules/regs  Take dental xrays (course required)  Coronal polishing (course required, and 1500 hrs experience) <b>Place topical local anesthesia</b>
Licensed Dental Assistant (LDA)	<b>19 y/o</b>  <b>Grad of a community college or OJT (but must have 3500 hrs chairside experience)</b>  <b>Current DANB certification or equivalent board approved exam to include clinical competency and testing</b>  <b>Pass NE jurisprudence exam</b>  <b>Become licensed with HHS and complete CE per UCA</b>	<b>Current duties per state rules/regs</b>  <b>Place dental sealants (with course)</b>  <b>Fit and cement crowns on primary teeth (with course)</b>  <b>Take final impressions/records for dental prosthesis (crowns, bridges, etc. with course)</b>	<b>Current duties per state rules/regs</b>

Abbreviations: OJT = on the job trained  
Credentiaing Act

DANB= Dental Assisting National Board

CE=Continuing Education

UCA = Uniform

CPR= cardiopulmonary resuscitation

Board = NE Board of Dentistry

## Proposal for Change in Levels of Dental Hygiene Practice

Functions not permitted: Dental Diagnosis, **Red** = new duties or requirements

Level of Dental Hygiene Practice	Requirements/ Recommendations	General Supervision (Dentist has authorized procedure but is not on premises)	Public Health Supervision (Dentist may not be present and services provided in public health or related healthcare settings)
Registered Dental Hygienist (RDH)	All current ones in statute	<p>Current scope of practice</p> <p>Local anesthesia—under general supervision/reversal agents</p> <p><b>Administer nitrous oxide (with course)—INDIRECT SUPERVISION</b></p> <p>Orofacialmyology<sup>1</sup></p> <p>Dental Hygiene Diagnosis</p> <p><b>Place Interim Therapeutic Restoration<sup>2</sup> (with course)</b></p> <p><b>Write prescriptions for mouthrinses and other topical products as well as fluoride products that help decrease one's risk for tooth decay (with course)</b></p> <p><b>Extract teeth with class IV mobility<sup>3</sup> and hopeless prognosis (course needed)</b></p> <p>Anything a licensed DA is allowed to do.</p> <p><b>Enameloplasty sealant technique (EST) (with course)</b></p>	
Public Health Dental Hygienist (PHRDH)	<p>Current RDH and have public health permit</p> <p>Proof of liability Insurance</p> <p>Authorization from and report to HHS</p>		<p>Full Dental Hygiene scope of practice</p> <p><b>Interim Therapeutic Restoration<sup>2</sup> (with course).</b></p> <p>Dental Hygiene Diagnosis</p> <p><b>Write prescriptions for mouthrinses and other topical products as well as fluoride products that help decrease one's risk for tooth decay (with course)</b></p> <p><b>Extraction of primary teeth (without anesthetic) and permanent teeth (Class IV mobility, hopeless prognosis, interfering with eating and daily functions, patient has no dental home<sup>4</sup>), with or without anesthesia). Needs standing order from dentist or physician. Course required.</b></p> <p>Orofacialmyology<sup>1</sup> with National Certification</p> <p><b>Adjust removable appliances/soft relines/</b></p>



			Palliative care to include smoothing of a rough edge of a tooth. (with course) Enameloplasty sealant technique (EST)(with course)
Expanded Function Registered Dental Hygienist (EFRDH)	Current RDH and have EFRDH license  Proof of liability Insurance  Completion of course with didactic and clinical components taught by an accredited dental school or has completed equivalent exam from another state. DANB developing national exam for restorative procedures.  Pass board approved exam	Current full scope of practice  Place and finish dental restorations and preparation of class I and class V restorations.	

1. Definition of Orofacialmyology: The practice of orofacial myology includes the evaluation and treatment of the following:

- a) Abnormal non-nutritive sucking habits (thumb, finger, pacifier etc), b) Other detrimental orofacial habits, c) Abnormal orofacial rest posture problems,
- d) Abnormal neuromuscular muscle patterns associated with inappropriate mastication, bolus formation, and deglutition, e) Abnormal functional breathing patterns, f) Abnormal swallowing patterns, g) Abnormal speech patterns (only if the COM has the speech-language pathology credentials required by his/her State).

The overall goals of orofacial myofunctional therapy are to assist in the creation, the restoration, and the maintenance of a normal and harmonious muscle environment. (International Association of Orofacialmyology. This already exists in statute. This is clean-up language.

2. Definition of Interim Therapeutic Restoration (ITR): Use of a glass ionomer (tooth colored restoration) where fluoride release is needed. ITR and ART (atraumatic/alternative restorative technique) have similar techniques but different therapeutic goals. ITR may be used in very young patients, uncooperative patients, or patients with special health care needs for whom traditional cavity preparation and/or placement of traditional dental restorations are not feasible or need to be postponed. Additionally, ITR may be used for caries control in children with multiple open carious lesions, prior to definitive restoration of the teeth. ART, endorsed by the World Health Organization and the International Association for Dental Research, is a means of restoring and preventing caries in populations that have little access to traditional dental care and functions as definitive treatment. This

ITR = Interim Therapeutic Restoration    ART = Atraumatic Restorative Technique

3. Palliative Care-- the cares given to at risk populations that relieves symptoms and enables them to perform their activities of daily living.

4. Dental Hygiene Diagnosis— The identification of an individual's health behavior, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. The dental hygiene diagnosis requires evidenced based critical analysis and interpretation of assessments in order to reach conclusions about the patient's dental hygiene treatment needs. The dental hygiene diagnosis provides the basis for the dental hygiene care plan.

5. Enameloplasty sealant technique(EST)—use of a specially designed bur for enlarging deep pit and fissures, always maintaining the preparation in enamel and then applying the sealant. This technique is called EST.

**Current Statute for Nebraska Dental Hygienists**

**38-1130. Licensed dental hygienist; functions authorized; when; department; duties; Health and Human Services Committee; report.**

(1) Except as otherwise provided in this section, a licensed dental hygienist shall perform the dental hygiene functions listed in section 38-1131 only when authorized to do so by a licensed dentist who shall be responsible for the total oral health care of the patient.

(2) The department may authorize a licensed dental hygienist to perform the following functions in the conduct of public health-related services in a public health setting or in a health care or related facility: Preliminary charting and screening examinations; oral health education, including workshops and inservice training sessions on dental health; and all of the duties that any dental assistant is authorized to perform.

(3)(a) The department may authorize a licensed dental hygienist to perform the following functions in the conduct of public health-related services to children in a public health setting or in a health care or related facility: Oral prophylaxis to healthy children who do not require antibiotic premedication; pulp vitality testing; and preventive measures, including the application of fluorides, sealants, and other recognized topical agents for the prevention of oral disease.

(b) Authorization shall be granted by the department under this subsection upon (i) filing an application with the department and (ii) providing evidence of current licensure and professional liability insurance coverage. Authorization may be limited by the department as necessary to protect the public health and safety upon good cause shown and may be renewed in connection with renewal of the dental hygienist's license.

(c) A licensed dental hygienist performing dental hygiene functions as authorized under this subsection shall (i) report authorized functions performed by him or her to the department on a form developed and provided by the department and (ii) advise the patient or recipient of services or his or her authorized representative that such services are preventive in nature and do not constitute a comprehensive dental diagnosis and care.

(4)(a) The department may authorize a licensed dental hygienist who has completed three thousand hours of clinical experience to perform the following functions in the conduct of public health-related services to adults in a public health setting or in a health care or related facility: Oral prophylaxis; pulp vitality testing; and preventive measures, including the application of fluorides, sealants, and other recognized topical agents for the prevention of oral disease.

(b) Authorization shall be granted by the department under this subsection upon (i) filing an application with the department, (ii) providing evidence of current licensure and professional liability insurance coverage, and (iii) providing evidence of three thousand hours of clinical experience. Authorization may be limited by the department as necessary to protect the public health and safety upon good cause shown and may be renewed in connection with renewal of the dental hygienist's license.

(c) A licensed dental hygienist performing dental hygiene functions as authorized under this subsection shall (i) report on a form developed and provided by the department authorized functions performed by him or her to the department and (ii) advise the patient or recipient of services or his or her authorized representative that such services are preventive in nature and do not constitute a comprehensive dental diagnosis and care.

(5) The department shall compile the data from the reports provided under subdivisions (3)(c)(i) and (4)(c)(i) of this section and provide an annual report to the Board of Dentistry and the State Board of Health.

(6) For purposes of this section:

(a) Health care or related facility means a hospital, a nursing facility, an assisted-living facility, a correctional facility, a tribal clinic, or a school-based preventive health program; and

(b) Public health setting means a federal, state, or local public health department or clinic, community health center, rural health clinic, or other similar program or agency that serves primarily public health care program recipients.

(7) Within five years after September 6, 2013, the Health and Human Services Committee of the Legislature shall evaluate the services provided by dental hygienists pursuant to this section to ascertain the effectiveness of such services in the delivery of oral health care and shall provide a report on such evaluation to the Legislature. The report submitted to the Legislature shall be submitted electronically.

Source: Laws 1986, LB 572, § 2; Laws 1996, LB 1044, § 415; Laws 1999, LB 800, § 5; R.S.1943, (2003), §

**38-1131. Licensed dental hygienist; procedures and functions authorized; enumerated.** When authorized by and under the general supervision of a licensed dentist, a licensed dental hygienist may perform the following intra and extra oral procedures and functions:

- (1) Oral prophylaxis, periodontal scaling, and root planing which includes supragingival and subgingival debridement;
- (2) Polish all exposed tooth surfaces, including restorations;
- (3) Conduct and assess preliminary charting, probing, screening examinations, and indexing of dental and periodontal disease, with referral, when appropriate, for a dental diagnosis by a licensed dentist;
- (4) Brush biopsies;
- (5) Pulp vitality testing;
- (6) Gingival curettage;
- (7) Removal of sutures;
- (8) Preventive measures, including the application of fluorides, sealants, and other recognized topical agents for the prevention of oral disease;
- (9) Impressions for study casts;
- (10) Application of topical and subgingival agents;
- (11) Radiographic exposures;
- (12) Oral health education, including conducting workshops and inservice training sessions on dental health;
- (13) Application or administration of antimicrobial rinses, fluorides, and other anticariogenic agents; and
- (14) All of the duties that any dental assistant is authorized to perform.

Source: Laws 1986, LB 572, § 3; Laws 1999, LB 800, § 7; R.S.1943, (2003), § 71-193.17; Laws 2007, LB247, § 25; Laws 2007, LB463, § 464. The changes made by LB 247 became operative June 1, 2007. The changes made by LB 463 became operative December 1, 2008.

**38-1132. Licensed dental hygienist; monitor analgesia; administer local anesthesia; when.** (1) A licensed dental hygienist may monitor nitrous oxide analgesia under the indirect supervision of a licensed dentist. (2) A licensed dental hygienist may be approved by the department, with the recommendation of the board, to administer local anesthesia under the indirect supervision of a licensed dentist. The board may prescribe by rule and regulation: The necessary education and preparation, which shall include, but not be limited to, instruction in the areas of head and neck anatomy, osteology, physiology, pharmacology, medical emergencies, and clinical techniques; the necessary clinical experience; and the necessary examination for purposes of determining the competence of licensed dental hygienists to administer local anesthesia. The board may approve successful completion after July 1, 1994, of a course of instruction to determine competence to administer local anesthesia. The course of instruction must be at an accredited school or college of dentistry or an accredited dental hygiene program. The course of instruction must be taught by a faculty member or members of the school or college of dentistry or dental hygiene program presenting the course. The board may approve for purposes of this subsection a course of instruction if such course includes:

- (a) At least twelve clock hours of classroom lecture, including instruction in (i) medical history evaluation procedures, (ii) anatomy of the head, neck, and oral cavity as it relates to administering local anesthetic agents, (iii) pharmacology of local anesthetic agents, vasoconstrictor, and preservatives, including physiologic actions, types of anesthetics, and maximum dose per weight, (iv) systemic conditions which influence selection and administration of anesthetic agents, (v) signs and symptoms of reactions to local anesthetic agents, including monitoring of vital signs, (vi) management of reactions to or complications associated with the administration of local anesthetic agents, (vii) selection and preparation of the armamentaria for administering various local anesthetic agents, and (viii) methods of administering local anesthetic agents;
- (b) At least twelve clock hours of clinical instruction during which time at least three injections of each of the anterior, middle and posterior superior alveolar, naso and greater palatine, inferior alveolar,

lingual, mental, long buccal, and infiltration injections are administered; and (c) Procedures, which shall include an examination, for purposes of determining whether the hygienist has acquired the necessary knowledge and proficiency to administer local anesthetic agents.

Source: Laws 1986, LB 572, § 4; Laws 1995, LB 449, § 1; Laws 1996, LB 1044, § 416; Laws 1999, LB 800, § 8; Laws 1999, LB 828, § 75; Laws 2003, LB 242, § 37; R.S.1943, (2003), § 71-193.18; Laws 2007, LB296, §329; Laws 2007, LB463, § 465. The changes made by LB 296 became operative July 1, 2007. The changes made by LB 463 became operative December 1, 2008.

**Proposed Guidelines for New Educational Requirements for Licensed Dental Assistants and Expanded Function Dental Hygienists in Nebraska**

1. EFRDHs must demonstrate the same level of competence expected of everyone licensed to perform a given procedure.
2. EFRDH educational programs must be conducted by institutions/programs accredited by the ADA Council on Dental Accreditation (CODA).
3. Instruction for specific procedures must be provided by practitioners who are licensed in Nebraska to perform that procedure.
4. Instruction must be provided by practitioners who are appointed as faculty by the CODA accredited institution offering the program.
5. Instruction must be given in existing courses or their equivalent for specific procedures and include requirements for demonstrating competency. Where possible expanded functions education should take place within existing dental assisting and dental hygiene programs.
6. Instruction may be divided into specific modules which may be taken all together or independently of each other. Examples could include: sealants, operative dentistry, prosthodontics, orthodontics, oral surgery, periodontics, others?
7. A certificate would be awarded for successful completion of each module as is now the case for radiology and coronal polishing.
8. In order to accommodate persons who may be employed or at a distance from an accredited institution. several delivery modes can be investigated, for example: semester/session courses in residence; a series of weekend courses; attendance for certain days of the week for longer times, use of distance learning technology for didactic work and resident attendance for clinic.
9. Different time periods need to be considered, for example; up to 80 contact hours per module for dental hygienists wishing to earn an operative certificate; up to 200 hours of didactic and clinical work for dental assistants wishing to earn a certificate in cases where they need to include coursework that licensed dental hygienists have already taken.
10. It is possible that educational institutions will need to seek approval from their governing boards and/or the Higher Education Coordinating Commission. This will require full proposals for the program and time for processing. An alternative might be to offer the programs as Continuing Education within the context of CE programs for each institution.

Taken from: **Position Paper of the ADAA/DANB Alliance, September, 2005**

Furthermore, the ADA's Comprehensive Policy Statement on Allied Dental Personnel stipulates that intraoral expanded functions should be performed by allied dental personnel "only under the direct supervision of a dentist."<sup>38</sup>

Moreover, the proposal emerging from the ADAA/DANB Alliance's research conforms to the principles outlined in the ADA's "Comprehensive Policy Statement on Allied Dental Personnel," which requires that the advocacy of functions that may be appropriately delegated to allied dental personnel, including dental assistants, be "based on (1) the best interests of the patient; (2) the education, training, and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings."<sup>39</sup> The ADA's policy further stipulates that regulations pertaining to the delegation of expanded functions "should specify (1) education and training requirements; (2) level of supervision by the dentist; (3) assurance of quality; and (4) regulatory controls to assure protection of the public."<sup>40</sup>

Delegation of duties to dental assistants can contribute to productivity enhancements and consequent capacity improvements only if the individuals to whom the duties are delegated are qualified and can perform the tasks expediently and competently. Attempting to increase productivity through delegation of duties to dental assistants necessarily entails evaluating a dental assistant's preparedness to accept the assignment of a particular task. The guidelines emerging from the DANB/ADAA Core Competencies Study have the potential to serve as an effective framework within which dentists may make staffing decisions and day-to-day productivity decisions that collectively affect the overall oral healthcare services infrastructure capacity. It is to be hoped that the acceptance of these guidelines on a national level will serve to expedite the realization of actual infrastructure capacity improvements.

**Uniform Credentialing Act 38-145. Continuing competency requirements; board; duties.**

(1) The appropriate board shall establish continuing competency requirements for persons seeking renewal of a credential.

(2) The purposes of continuing competency requirements are to ensure (a) the maintenance by a credential holder of knowledge and skills necessary to competently practice his or her profession, (b) the utilization of new techniques based on scientific and clinical advances, and (c) the promotion of research to assure expansive and comprehensive services to the public.

(3) Each board shall consult with the department and the appropriate professional academies, professional societies, and professional associations in the development of such requirements.

(4)(a) For a profession for which there are no continuing education requirements on December 31, 2002, the requirements may include, but not be limited to, any one or a combination of the continuing competency activities listed in subsection (5) of this section.

(b) For a profession for which there are continuing education requirements on December 31, 2002, continuing education is sufficient to meet continuing competency requirements. The requirements may also include, but not be limited to, any one or a combination of the continuing competency activities listed in subdivisions (5)(b) through (5)(p) of this section which a credential holder may select as an alternative to continuing education.

(5) Continuing competency activities may include, but not be limited to, any one or a combination of the following:

(a) Continuing education;

(b) Clinical privileging in an ambulatory surgical center or hospital as defined in section 71-405 or 71-419;

(c) Board certification in a clinical specialty area;

(d) Professional certification;

(e) Self-assessment;

(f) Peer review or evaluation;

(g) Professional portfolio;

(h) Practical demonstration;



- (i) Audit;
- (j) Exit interviews with consumers;
- (k) Outcome documentation;
- (l) Testing;
- (m) Refresher courses;
- (n) Inservice training;
- (o) Practice requirement; or
- (p) Any other similar modalities.

#### Rules & Regs regarding Continuing Competency

Chapter 56-005 CONTINUING COMPETENCY REQUIREMENTS: Each dentist and dental hygienist holding an active credential within the state must, on or before the date of expiration of the credential, comply with the continuing competency requirements for his/her profession, unless the requirements are waived in accordance with 172 NAC 56-006.03 and 56-006.04. Individuals that hold a temporary dentist license are not required to comply with continuing competency requirements. Each credentialed individual is responsible for maintaining certificates or records of continuing competency activities.

56-005.01 On or before the expiration date of the credential, the credential holder must complete 30 hours of acceptable continuing competency requirements in the 24-month preceding the expiration date of the credential.

56-005.02 Acceptable Continuing Competency Activities:

1. State and National meetings, i.e., a meeting of the local, state, or American Dental Association, local, state, or American Dental Hygiene Association, National Dental Association, and/or educational programs sponsored by the recognized specialty groups in dentistry of the American Dental Association;
  - a. One hour credit for each hour of attendance, and only the portion of such meeting which meets the definition of continuing education can be accepted for credit. EFFECTIVE NEBRASKA DEPARTMENT OF 172 NAC 56 6/23/12 HEALTH AND HUMAN SERVICES

2. District meetings and Study Clubs. In order to qualify as a Study Club in the State of Nebraska, the Dental Study Club must have a charter or constitution, officers, and consist of at least four licensed members. The Study Club must submit a list of meetings, including length, date and topics by March 1 of the reporting period;
    - a. One hour credit for each hour of attendance, and only the portion of such meeting which meets the definition of continuing education can be accepted for credit.
  3. Formal education courses which relate directly to the practice of dentistry or dental hygiene;
    - a. One hour credit for each hour of attendance.
  4. University-sponsored courses in continuing education in dentistry or dental hygiene;
    - a. One hour credit for each hour of attendance.
  5. Licensee acting as table clinician or lecturer to licensed dentists, licensed dental hygienists or dental auxiliaries or licensee attending table clinics;
    - a. One hour credit for each hour of presentation or attendance; allowable credit limited to 2 hours within a 24-month renewal period.
  6. Home study with testing mechanism. If there is not a testing mechanism or certificate of completion, the licensee must submit an abstract or resume of the material covered to the Board of Dentistry. The abstract or resume must be written by only the licensee and will be reviewed by members of the Board's subcommittee on continuing education;
    - a. One hour credit for each hour of study; allowable credit limited to 10 hours within a 24-month renewal period.
  7. Direct clinical observation;
    - a. One hour credit for each hour of direct clinical observation; allowable credit limited to 2 hours within a 24-month renewal period.
  8. Initial Cardiopulmonary Resuscitation (CPR) certification or CPR re-certification;
    - a. One hour credit for each hour of study;
    - b. Allowable credit limited to 10 hours for initial CPR certification within a 24-month renewal period; and
    - c. Allowable credit limited to 4 hours for CPR re-certification within a 24-month renewal period.
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9. Faculty Overseeing Student Dental Clinics;
    - a. One hour credit for each hour of faculty overseeing student dental clinics; allowable credit limited to 5 hours within a 24-month renewal period.
  10. Dental Public Health continuing education;
    - a. One hour credit for each hour of dental public health continuing education; allowable credit limited to 5 hours within a 24-month renewal period.
  11. Ethics and Professionalism continuing education;
    - a. One hour credit for each hour of ethics and professionalism continuing education; allowable credit limited to 5 hours within a 24-month renewal period.
  12. Well-being (Substance Abuse) continuing education;
    - a. One hour credit for each hour of well-being (substance abuse) continuing education; allowable credit limited to 5 hours within a 24-month renewal period.

**38-1118. Dental hygienists; application for license; examination; qualifications; license.**

(1) Every applicant for a license to practice dental hygiene shall (a) present proof of graduation from an accredited dental hygiene program, (b) pass an examination approved by the Board of Dentistry which shall consist of the National Board Dental Hygiene Examination as constructed and administered by the American Dental Association Joint Commission on National Dental Examinations, (c) demonstrate the applicant's skill in clinical dental hygiene by passing the practical examination administered by the Central Regional Dental Testing Service or any other regional or state practical examination that the Board of Dentistry determines to be comparable to such practical examination, (d) pass a jurisprudence examination approved by the board that is based on the Nebraska statutes, rules, and regulations governing the practice of dentistry and dental hygiene, and (e) demonstrate continuing clinical competency as a condition of licensure if required by the board.

**Summary of University of Minnesota Restorative Expanded Functions:  
An 80-hour Training Program**

**Restorative Expanded Functions: An 80-Hour Training Program**

**MINNESOTA LICENSED DENTAL HYGIENISTS AND DENTAL ASSISTANTS:**

The Minnesota Dental Practice Acts allows a licensed dental assistant or dental hygienist to perform certain restorative procedures under indirect supervision upon completion of a board-approved course and issuance of a Restorative Functions (RF) credential. The procedures allowed include: (1) place, contour, and adjust amalgam restorations; (2) place, contour, and adjust glass ionomer; (3) adapt and cement stainless steel crowns; and (4) place, contour, and adjust Class I and Class V supragingival composite restorations where the margins are entirely within the enamel.

This Minnesota Board of Dentistry approved training program will give you the knowledge and practical skills to confidently perform restorative expanded functions in practice. You will benefit from one-on-one interaction with experienced instructors who will share a myriad of clinical tips that come from an average of 30 years of practice and teaching experience in restorative and pediatric dentistry.

**Benefits/Objectives**

**Phase One:** *During the 80-hour classroom and pre-clinical portion of the continuing dental education program, you will learn how to:*

- recognize properties and indications for use of different dental materials.
- recognize and duplicate normal dental anatomy in the pediatric and adult dentition.
- manipulate, condense, place and contour amalgam restorations.
- manipulate, place, cure and polish glass ionomer and Class I & V composite restorations.
- adapt, cement and remove excess cement from stainless steel crowns on primary teeth.
- maintain a dry field during the placement of restorations.
- select the appropriate composite shade.
- evaluate and adjust the occlusion for amalgam, glass ionomer, and composite restorations.
- identify and correct deficiencies in amalgam, glass ionomer and composite restorations, as well as stainless steel crowns.
- utilize a restorative expanded function auxiliary (RF) in practice.

**Phase Two:** *Upon completion of the 80-hour classroom pre-clinical portion of the program, you will be required to complete the following procedures on patients\* under the personal supervision (chairside) of a dentist.*

- amalgam—5 primary and 5 permanent teeth/surfaces
- glass ionomer—3 primary and 2 permanent teeth/surfaces
- stainless steel crowns—4 primary
- composite—2 primary and 3 permanent teeth/surfaces

\*These are the minimum requirements and must include at least 12 patients. Patient experiences will be completed in a dental practice.

**Phase Three:** *After successful completion of phase one and two of this continuing dental education program, you will arrange for a credentialing examination by one of the course instructors to be conducted in your dental office. For the examination you will:*

- perform two of the four restorative procedures while the credentialing instructor observes and verifies satisfactory performance.
- review with the credentialing instructor previously completed patient records for the other two restorative procedures. Records will include appropriate photographs, radiographs and study models.

**Timing:** Please note that you must complete the entire 80-hour training program within one year and that you must also complete the clinical credentialing examination within one year of completing the training program.

**Who Should Attend**

Licensed dental assistants and dental hygienists who want to receive the educational training required to perform restorative expanded functions on patients in the state of Minnesota.

**Educational Methods**

Illustrated lectures, discussion, demonstrations, laboratory exercises, patient simulation on manikins, supervised patient treatment, and clinical competency assessment.

## **Modules Materials for Public Health Hygienists Taken from Kansas ECPIII**

<b>Course Description</b>
<b>The ECP III Training Course is designed to prepare a registered dental hygienist to apply for the Kansas Extended Care Permit III. Hygienists with the ECP III certificate can practice under the sponsorship of a dentist in a variety of public health settings including, schools and long term care facilities in Kansas. CR/NCR</b>
<b>Assigned Learning Resources</b>
<b>Required: Online Modules/Reading Assignments and Lab Day</b> <b>All materials included with the on-line modules.</b>
<b>Major Course Goals/Objectives</b>
<b>The course will prepare the student to:</b> <ol style="list-style-type: none"><li><b>1. Describe the requirements of ECP III legislation.</b></li><li><b>2. Assess for recognition and subsequent referral for further dental care.</b></li><li><b>3. Remove decayed tooth structure using hand instruments.</b></li><li><b>4. Place various types of temporary restoration.</b></li><li><b>5. Adjust dentures to relieve sore spots.</b></li><li><b>6. Place temporary soft re-liners on dentures.</b></li><li><b>7. Smooth rough tooth surfaces using a slow speed handpiece.</b></li><li><b>8. Extract primary teeth with Class IV mobility.</b></li><li><b>9. Manage dental emergencies</b></li><li><b>10. Understand various pharmacological agents such as antibiotics and antifungals.</b></li></ol>

## Course Schedule

### The Following Items Are to Be Completed On-line Prior to the Lab Practical

#### *Modules:*

1. *Course Basics*
2. *The Legislation-Details from the Dental Practice Act*
3. *Assessment for Recognition of Decay and Dental Referral*
4. *Atraumatic Restorative Treatment*
5. *Temporary Restoration Placement*
6. *Denture Adjustments and Liners*
7. *Extraction of Mobile Primary Teeth*
8. *Pharmacological use of Chlorhexidine, Fluorides, Antibiotics & Antifungals*
9. *Emergencies*

*Discussion Board Postings: Students must post their feedback to each module and respond to one additional posting of another participant/student in the course.*

**MANDATORY LAB PRACTICAL TO BE HELD AT UMKC SCHOOL OF DENTISTRY**

## Competencies Addressed in the Course

1. STUDENTS WILL DEMONSTRATE EFFECTIVE MANAGEMENT OF INFORMATION TECHNOLOGY
2. STUDENTS WILL UTILIZE CRITICAL THINKING AND PROBLEM SOLVING SKILLS TO FACILITATE DECISION MAKING
3. STUDENTS WILL ASSUME RESPONSIBILITY FOR PROFESSIONAL ACTIONS AND CARE BASED ON ETHICAL AND PROFESSIONAL BEHAVIOR, ACCEPTED SCIENTIFIC THEORIES AND ACCEPTED STANDARDS OF CARE
4. STUDENTS WILL DEMONSTRATE THE ABILITY TO MANAGE THEMSELVES AND OTHERS AND WORK AS A TEAM MEMBER

## Core requirements and methods of evaluation

The student will complete each module by reviewing the resource materials, power-point and recorded tegrity session. The student will be asked to complete an on-line quiz at the conclusion of each module. The student must earn a score of 80% on each module quiz in order to receive credit for the course material and progress to the Lab Practical portion of the course. Quizzes may be repeated until a score of 80% is achieved.

Following successful completion of each module, the student will be eligible to participate in the course lab practical. Successful completion of this lab practical is mandatory to receive credit for the course. At this practical the student will be assessed for competency in each of the following areas:

### REMOVING MOBILE PRIMARY

TEETH The Student will:

1. Identify teeth to be extracted by describing the criteria of under ECP II regulations.
2. Identify armamentarium by naming and selecting the correct forceps for each arch.
3. Distinguish between periosteal elevators.
4. Demonstrate proper placement of instruments on a typo-dont tooth

### DENTURE LINERS AND

ADJUSTMENT The student will:

1. Describe evidence of a sore spot
2. Identify area in denture for adjustment
3. Demonstrate proper usage of Thompson stick and PIP
4. Demonstrate proper denture adjustment and finishing using the correct armamentarium.
5. Demonstrate careful use of instruments
6. Verbalize types of liners and when each might be best used
7. Mix a lining material
8. Properly finish a liner in a denture

### DECAY REMOVAL AND TEMPORARY RESTORATION

PLACEMENT The student will:

1. Identify decay on an extracted tooth
2. Utilize instruments to properly remove decay
3. Fabricate temporary restoration material
4. Place temporary restoration material
5. Utilize the proper instruments to smooth the material
6. Finish the restoration using the proper smoothing instruments

### SMOOTHING A ROUGH TOOTH

EDGE The student will:

1. Identify the armamentarium
2. Demonstrate the smoothing process



## Appendix J

### **Chart Explaining the Current Statutes for Dental Hygiene and Dental Assistants vs. The Changes Which Take Place From the Proposal**

#### **DENTAL HYGIENIST**

<b>Current Regulated Procedures</b>	<b>Current Supervision Level</b>
-------------------------------------	----------------------------------

Administer Local Anesthesia	Indirect Supervision
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Monitor Nitrous Oxide and Oxygen Inhalation Analgesia	Indirect Supervision
---	----------------------

(The dentist puts the mask on the patient, adjusts the level of analgesia and then leaves the room allowing the hygienist to observe the patient while performing hygiene procedures. If the patient experiences any problems the hygienist must call the dentist to come back to the patient to adjust the level of analgesia being administered.)

<b>Proposed Changes</b>	<b>Proposed Supervision Level</b>
-------------------------	-----------------------------------

Administer Local Anesthesia and Reversal Agents	General Supervision
---	---------------------

Administer, Monitor and Adjust Nitrous Oxide and Oxygen Inhalation Analgesia-Indirect Supervision	
---	--

(The hygienist will be allowed to put the mask on the patient, adjust the level of analgesia and monitor the patient while performing hygiene procedures. This will only be allowed if the dentist is physically present in the facility.)

#### **DENTAL ASSISTANT**

<b>Currently Allowed Procedures</b>	<b>Current Supervision Level</b>
-------------------------------------	----------------------------------

Assist with Nitrous Oxide and Oxygen Inhalation Analgesia	Direct Supervision
---	--------------------

(The assistant is allowed to be present when the patient is receiving Nitrous Oxide and Oxygen Inhalation Analgesia and assist the dentist while performing dental procedures.)

#### **Proposed Changes**

Monitor a patient on Nitrous Oxide and Oxygen Inhalation Analgesia	Direct Supervision
--	--------------------

(The assistant will be allowed to observe the patient's responsiveness, color, and respiratory rate; recognizing adverse reactions or complications and report them to the dentist immediately.)

**Proposed Regulations Governing the Practice of Dental Hygienists Approved to Monitor, Titrate, Administer and Adjust Nitrous Oxide and Oxygen Inhalation Analgesia/Administer Local Anesthesia**

**Scope of Regulations:** These regulations govern the practice of dental hygienists approved to monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia: administer local anesthesia.

**Definitions**

Approved Course means a course which the Board has approved for the education and training of dental hygienists to monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia: administer local anesthesia.

Board means the Board of Dentistry.

Clock hour means 50 to 60 minutes.

Department means the Department of Health of the State of Nebraska.

Indirect Supervision means the licensed dentist authorizes the procedure to be performed by an approved dental hygienist and the licensed dentist is physically present on the premises when such procedure is being performed by the dental hygienist.

Licensed Dental Hygienist means an individual who holds a current Nebraska license to practice dental hygiene.

Licensed Dentist means an individual who holds a current Nebraska license to practice dentistry.

**Requirements for Course Approval** Pursuant to the provision of Neb. Rev. Stat. 71-193.18, the Department, upon the recommendation of the Board, shall prescribe a curriculum which licensed dental hygienists must complete to become approved to monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia, administer local anesthesia and establish minimal standards for approved courses.

The course of instruction must be at an accredited school or college of dentistry, an accredited dental hygiene program or a nationally accredited program approved by the board.

The course of instruction must be taught by a faculty member or members of the school or college of dentistry, dental hygiene program presenting the course or a dental anesthesiologist.

The course to monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia shall be no less than six didactic hours of instruction and two patient contact hours, additional supervised clinical experience showing management of children (aged twelve and under) and medically compromised adults, the course shall include, but not be limited to:

Historical, philosophical and psychological aspects of anxiety and pain control.

Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations;

Definitions and descriptions of physiological and psychological aspects of anxiety and pain;

Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and unconscious state;

Review of pediatric and adult respiratory and circulatory physiology and related anatomy;

Pharmacology of agents used in nitrous oxide and oxygen inhalation analgesia, including drug interactions and incompatibilities;

Indications and contraindications for use of nitrous oxide and oxygen inhalation analgesia;

Prevention, recognition and management of complications and life-threatening situations;

Description and use of nitrous oxide and oxygen inhalation analgesia equipment;

Administration of local anesthesia in conjunction with nitrous oxide and oxygen inhalation analgesia techniques;

Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response;

Discussion of abuse potential;

The course shall include procedures for purposes for determining whether the hygienist has acquired the necessary knowledge and proficiency to monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia. Such procedures shall include, but not be limited to: An examination which determines the competence of licensed hygienists to monitor,

titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia and required to pass.

**Requirements for Approval of A Licensed Dental Hygienist to Monitor, Titrate, Administer and Adjust Nitrous Oxide and Oxygen Inhalation Analgesia.** No licensed dental hygienist may monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia unless they have been approved by the Department of Health, upon the recommendation of the Board of Dentistry, pursuant to Neb. Rev. Stat. 71-193.18.

An Applicant for approval to monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia must:

- Have a current license to practice dental hygiene in the State of Nebraska

- Have successfully completed an approved course after (date to be determined)

- Have a current certification of basic life-support skills for healthcare providers.

Submit to the Department:

- A completed application form provided by the Department

- Proof of successful completion of an approved course:

- All Applicants taking out-of-state courses must provide course syllabus, name and location of institution, and date of course; and

- The required fee.

The Department shall act within one hundred fifty (150) days of receipt of the completed application for approval to monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia.

If the Department, upon the recommendation of the Board, proposes to deny approval, the applicant shall be given an opportunity for a hearing before the Department and shall have the right to present evidence on his or her own behalf. Hearings before the department shall be conducted in accordance with the Administrative Procedures Act and 164 NAC 1, the Rules of Practice and Procedure for the Department.

**Practice by a Licensed Dental Hygienist Approved to Monitor, Titrate, Administer and Adjust Nitrous Oxide and Oxygen Inhalation Analgesia.**

Only those licensed dental hygienists approved pursuant to Section (to be determined) of these regulations may monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia.

A licensed dental hygienist approved to monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia may do so only under the indirect supervision of a licensed dentist.

Following monitor, titrate, administer and adjust nitrous oxide and oxygen inhalation analgesia by a licensed dental hygienist the following information shall be documented in the patient record:

Informed Consent from the patient, parent, guardian or care giver

Current baseline vital signs

Titrated level of Nitrous Oxide and Oxygen Administered

Length of the procedure

Any Complications

(Keep all the current regulations for administration of local anesthesia by dental hygienists)

**Proposed Statutes Governing the Practice of Dental Hygienists Approved to Administer, Monitor and Adjust Nitrous Oxide and Oxygen Inhalation Analgesia/Administer Local Anesthesia and Reversal Agents**

**38-1105 Analgesia, defined.** Analgesia means the diminution or elimination of pain in the conscious patient.

**38-1106 Board, defined.** Board means the Board of Dentistry.

**38-1107 Dental Assistant, defined.** Dental assistant means a person, other than a dental hygienist, employed by a licensed dentist for the purpose of assisting such dentist in the performance of his or her clinical and clinical-related duties.

**38-1109 General Supervision, defined.** General supervision means the directing of the authorized activities of a ~~dental hygienist or dental assistant~~ dental auxiliary by a licensed dentist and shall not be construed to require the physical presence of the supervisor when directing such activities.

**38-1110 Indirect Supervision, defined.** Indirect supervision means supervision when the licensed dentist authorizes the procedure to be performed by a dental ~~assistant~~ auxiliary and the licensed dentist is physically present on the premises when such procedure is being performed by the dental ~~assistant~~ auxiliary.

**38-1111 Inhalation Analgesia, defined.** Inhalation analgesia means the administration of nitrous oxide and oxygen to diminish or eliminate pain in a conscious patient.

**New # Monitor, defined.** To observe the patient's responsiveness, color, and respiratory rate; recognizing adverse reactions or complications and report them to the dentist immediately.

**New # Titration, defined.** Administration of incremental doses of a drug until a desired effect is reached.

**38-1131 Administers local anesthesia,** reversal agents and/or nitrous oxide and oxygen inhalation analgesia in connection with a dental operation;

**38-1132 Licensed Dental Hygienist;** pertaining to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia; ~~administer local anesthesia;~~ when. (1) A licensed dental hygienist may be approved by the department, with recommendation by the board, to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia under the indirect supervision of a licensed dentist. The board may prescribe by rule and regulation: The necessary education and preparation; the necessary clinical experience; and the necessary

examination for purposes of determining the competence of licensed dental hygienists to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia. The board may approve successful completion of a course of instruction to determine competence to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia. The course of instruction must be at an accredited school or college of dentistry, an accredited dental hygiene program or a nationally accredited program approved by the board. The course of instruction must be taught by a faculty member or members of the school or college of dentistry, dental hygiene program presenting the course or a dental anesthesiologist. The board may approve for the purposes of this subsection a course of instruction if such course includes:

- (a) At least six didactic hours of instruction and two patient contact hours, additional supervised clinical experience showing management of children (aged twelve and under) and medically compromised adults, including instruction in (i) historical, philosophical, psychological aspects of anxiety and pain control, (ii) patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations, (iii) definitions and descriptions of physiological and psychological aspects of anxiety and pain, (iv) description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and unconscious state, (v) review of pediatric and adult respiratory and circulatory physiology and related anatomy, (vi) pharmacology of agents used in nitrous oxide and oxygen inhalation analgesia, including drug interactions and incompatibilities, (vii) indications and contraindications for use of nitrous oxide and oxygen inhalation analgesia, (viii) prevention, recognition and management of complications and life-threatening situations, (ix) description and use of nitrous oxide and oxygen inhalation analgesia equipment, (x) administration of local anesthesia in conjunction with nitrous oxide and oxygen inhalation analgesia techniques, (xi) importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response, (xii) discussion of abuse potential; and
- (b) Procedures, which shall include an examination, for purposes of determining whether the hygienist has acquired the necessary knowledge and proficiency to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia.

(2) A licensed dental hygienist may be approved by the department, with the recommendation of the board, to administer local anesthesia and reversal agents under the general supervision of a licensed dentist. The board may prescribe by rule and regulation: The necessary education and preparation, which shall include, but not be limited to, instruction in the areas of head and neck anatomy, osteology, physiology, pharmacology, medical emergencies, and clinical techniques; the necessary clinical experience; and the necessary examination for purposes of determining the competence of licensed dental hygienists to administer local anesthesia and reversal agents. The board may approve successful completion after July 1, 1994, of a course of instruction to determine competence to administer local anesthesia and reversal agents. The course of instruction must be at an accredited school or college of dentistry or an accredited dental hygiene program. The course of instruction must be taught by a faculty member or members of the school or college of dentistry or dental hygiene program presenting the course.

The board may approve for the purposes of this subsection a course of instruction if such course includes:

- (a) At least twelve clock hours of classroom lecture, including instruction in (i) medical history evaluation procedures, (ii) anatomy of the head, neck, and oral cavity as it relates to administering local anesthetic agents and reversal agents, (iii) pharmacology of local anesthetic agents and reversal agents, vasoconstrictor, and preservatives, including physiologic actions, types of anesthetics and maximum dose per weight, (iv) systemic conditions which influence selection and administration of anesthetic agents, (v) signs and symptoms of reactions to local anesthetic agents and reversal agents, including monitoring of vital signs, (vi) management of reactions or complications associated with the administration of local anesthetic agents and reversal agents, (vii) selection and preparation of the armamentaria for administering various local anesthetic agents and reversal agents, and (viii) methods of administering local anesthetic agents and reversal agents;
- (b) At least twelve clock hours of clinical instruction during which time at least three injections of each of the anterior, middle and posterior superior alveolar, naso and greater palatine, inferior alveolar, lingual, mental, long buccal, and infiltration injections are administered; and
- (c) Procedures, which shall include an examination, for purposes of determining whether the hygienist has acquired the necessary knowledge and proficiency to administer local anesthetic agents and reversal agents.

**38-1142 Presence of licensed dental hygienist or dental assistant required.** General anesthesia, deep sedation, moderate sedation or minimal sedation shall not be administered by a dentist without the presence and assistance of a licensed dental hygienist or a dental assistant.

**38-1143 Assistant; certification required.** Any person who assists a dentist in the administration of general anesthesia, deep sedation, moderate sedation ~~or~~ minimal sedation or nitrous oxide and oxygen inhalation analgesia shall be currently certified in Basic Life-Support Skills for Healthcare Providers.

#### **Add to Statutes**

**38-New # Dental Assistants; monitor nitrous oxide and oxygen inhalation analgesia; when.** A dental assistant may monitor nitrous oxide and oxygen inhalation analgesia under the direct supervision of a licensed dentist. A dental assistant may be approved by the department, with recommendation by the board, to monitor nitrous oxide and oxygen inhalation analgesia under the direct supervision of a licensed dentist. The board may prescribe by rule and regulation: The necessary education and preparation; the necessary clinical experience; and the necessary examination for purposes of determining the competence of dental assistants to monitor nitrous oxide and oxygen inhalation analgesia. The board may approve successful completion of a course of instruction to determine competence to monitor nitrous oxide and oxygen inhalation analgesia. The course of instruction must be at an accredited school or college of dentistry, an accredited dental hygiene program or a nationally accredited program approved



by the board. The course of instruction must be taught by a faculty member or members of the school or college of dentistry, dental hygiene program presenting the course or a dental anesthesiologist.

**38-New # Reversal Agents, defined.** An injectable agent that when administered will terminate the numbing effect of local anesthesia

### **Possible Regulations of Title 172 Chapter 57 (Pertains to Only Dental Hygienists)**

**Scope of Regulations:** These regulations govern the practice of dental hygienists approved to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia/ administer local anesthesia and reversal agents in Nebraska

#### **Definitions:**

002.01 **Approved Course means** a course which the Board has approved for the education and training of dental hygienists to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia/ administer local anesthesia and reversal agents.

002.02 **Board means** the Board of Dentistry

002.03 **Clock hour means** 50 to 60 minutes.

002.04 **Department means** the Department of Health of the State of Nebraska.

002.05 **General Supervision means** the directing of the authorized activities of a dental hygienist by a licensed dentist and shall not be construed to require the physical presence of the supervisor when directing such activities.

002.06 **Indirect Supervision means** the licensed dentist authorizes the procedure to be performed by an approved dental hygienist and the licensed dentist is physically present on the premises when such procedure is being performed by the dental hygienist.

002.07 **Licensed Dental Hygienist means** an individual who holds a current Nebraska licensed to practice dental hygiene.

002.08 **Licensed Dentist means** an individual who holds a current Nebraska license to practice dentistry.

#### **Requirements for Course Approval:**

Pursuant to the provision of Neb. Rev. Stat. 38-1132, the Department, upon the recommendation of the Board, shall prescribe a curriculum which licensed dental hygienists must complete to become approved to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia, administer local anesthesia and reversal agents and establish minimal standards for approved courses.

003.01 The course of instruction must be at an accredited school or college of dentistry, an accredited dental hygiene program or a nationally accredited program approved by the board.

003.02 The course to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia shall be no less than six didactic hours of instruction and two patient contact hours,

additional supervised clinical experience showing management of children (aged twelve and under) and medically compromised adults, the course shall include, but not be limited to:

003.02A Historical, philosophical and psychological aspects of anxiety and pain control.

003.02B Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations;

003.02C Definitions and descriptions of physiological and psychological aspects of anxiety and pain;

003.02D Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and unconscious state;

003.02E Review of pediatric and adult respiratory and circulatory physiology and related anatomy;

003.02F Pharmacology of agents used in nitrous oxide and oxygen inhalation analgesia, including drug interactions and incompatibilities;

003.02G Indications and contraindications for use of nitrous oxide and oxygen inhalation analgesia;

003.02H Prevention, recognition and management of complications and life-threatening situations;

003.02I Description and use of nitrous oxide and oxygen inhalation analgesia equipment;

003.02J Administration of local anesthesia in conjunction with nitrous oxide and oxygen inhalation analgesia techniques;

003.02K Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response;

003.02L Discussion of abuse potential; and

003.03 The course shall include procedures for purposes for determining whether the hygienist has acquired the necessary knowledge and proficiency to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia. Such procedures shall include, but not be limited to:

003.03A An examination which determines the competence of licensed hygienists to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia and required to pass.

### **Requirements for Approval of A Licensed Dental Hygienist to Administer, Monitor and Adjust Nitrous Oxide and Oxygen Inhalation Analgesia:**

No licensed dental hygienist may administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia unless they have been approved by the Department of Health, upon the recommendation of the Board of Dentistry, pursuant to Neb. Rev. Stat. 38-1132

004.01 An Applicant for approval to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia must:

004.01A Have a current license to practice dental hygiene in the State of Nebraska

004.01B Have successfully completed an approved course after (date to be determined)

004.01C Have a current certification of Basic Life-Support Skills for Healthcare Providers.

004.01D Submit to the Department:

004.01D(1) Completed application form provided by the Department;

004.01D(2) Proof of successful completion of an approved course

004.01D(2) a all applicants taking out-of-state courses must provide course syllabus, name and location of institution, and date of course; and

004.01D(3) The required fee.

**Practice by a Licensed Dental Hygienist Approved to Administer, Monitor and Adjust Nitrous Oxide and Oxygen Inhalation Analgesia.**

005.01 Only those licensed dental hygienists approved pursuant to Section (to be determined) of these regulations may administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia.

005.02 A licensed dental hygienist approved to administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia may do so only under the indirect supervision of a licensed dentist.

005.03 Following administer, monitor and adjust nitrous oxide and oxygen inhalation analgesia by a licensed dental hygienist the following information shall be documented in the patient record:

005.03A Informed consent from the patient, parent, guardian or caregiver;

005.03B Current baseline vital signs;

005.03C Titrated level of nitrous oxide and oxygen administered;

005.03D Length of the procedure; and

005.03E Any complications

**Possible Regulations of Title 172 Chapter 53**

**Requirements for Course Approval for Dental Assistants**

**006 Monitor Nitrous Oxide and Oxygen Inhalation analgesia.** A dental assistant is hereby authorized, under the direct supervision of a licensed dentist, to monitor nitrous oxide and oxygen inhalation analgesia, but may not be authorized to do so on or after (date to be determined), unless they have met the following requirements:

006.01 Attained the age of eighteen (18); and

006.02 One of the following:

006.02A Have graduated from a dental assisting training program which is accredited by the American Dental Association (ADA) and includes a monitoring nitrous oxide and oxygen inhalation analgesia course; or

006.02B Have one (1) year (a minimum of 1500 hours) of clinical work experience as a dental assistant and have successfully completed a course in monitoring nitrous oxide and oxygen inhalation analgesia which is approved by the Board and Department.

006.02C Have a current certification of Basic Life-Support Skills for Healthcare Providers.

**006.03 Criteria for Approval of a Course on Monitoring Nitrous Oxide and Oxygen Inhalation Analgesia for Dental Assistant**

006.03A The institution administering the course on monitoring nitrous oxide and oxygen inhalation analgesia must be accredited by the American Dental Association or a dental anesthesiologist or be a course in monitoring nitrous oxide and oxygen inhalation analgesia which is approved by the Board and Department.

006.03B The course shall include procedures for purposes for determining whether the dental assistant has acquired the necessary knowledge and proficiency to monitor nitrous oxide and oxygen inhalation analgesia.

006.03C The course shall include an examination which determines the competence of the dental assistant to monitor nitrous oxide and oxygen inhalation analgesia and required to pass.